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Review of Primary Care Services – **Hywel Dda University Health Board**

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

The person who delivered the work was David Poland.

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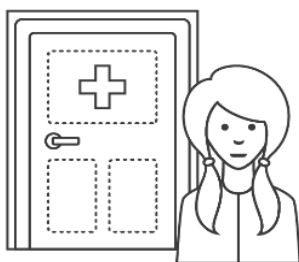
Summary report

Background

- 1 The [national primary care plan](#)¹ defines primary care as follows:
'Primary care is about those services which provide the first point of care, day or night for more than 90% of people's contact with the NHS in Wales. General practice is a core element of primary care: it is not the only element – primary care encompasses many more health services, including, pharmacy, dentistry, and optometry. It is also – importantly – about coordinating access for people to the wide range of services in the local community to help meet their health and wellbeing needs.'
- 2 **Exhibit 1** shows the important role that primary care plays in Wales.

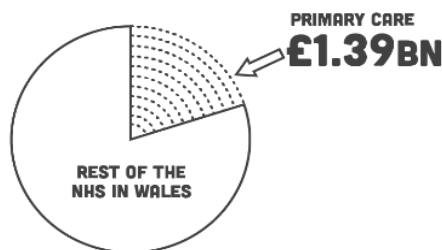
Exhibit 1: why is primary care important in Wales?

First point of contact



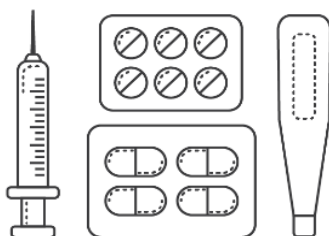
Primary care is the first port of call for the majority of people who use health services.

Spending on primary care



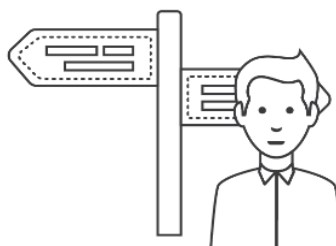
In 2016-17, the NHS in Wales spent £1.39 billion on primary care, which is around a fifth of the total NHS spending in Wales.

Prevention and early intervention



Primary care is also important because of its focus on promoting well-being, early intervention and preventing people's conditions from getting worse.

Coordinating care



Primary care plays an important role in co-ordinating people's care, acting as a gateway to many other services.

¹ Our plan for a primary care service for Wales up to March 2018. Welsh Government. February 2015.

Source: Wales Audit Office. Note: Primary care expenditure is not consistently categorised by health boards. As such, it is likely that the £1.39bn figure from the NHS accounts does not represent the totality of primary care expenditure.

- 3 Wales has had plans for many years that stress the importance of primary care. The plans aim to rebalance the system of care by moving resources towards primary and community care. The national primary care plan aims for a 'social model' that promotes physical, mental and social wellbeing, rather than just an absence of ill health. The core principles in the plan are: planning care locally, improving access and quality; equitable access; a skilled local workforce; and strong leadership.
- 4 The national primary care plan and the NHS Wales planning framework place an expectation on health boards to set out plans for primary care as part of their integrated medium-term plan. Each plan should explain how the health board will develop the capacity and capability of primary care services.
- 5 To support the implementation of the national plan, NHS Wales issued a workforce plan². Health boards are expected to put in place actions to secure, manage and support a sustainable primary care workforce shaped by local population needs and by prudent healthcare principles.
- 6 Primary care clusters are the main mechanism for planning services at a community level and they were first established in 2009³. Clusters are groups of neighbouring GP practices, other primary care services and partner organisations such as the ambulance service, councils and the third sector. There are 64 clusters (also known as neighbourhood care networks) in Wales. Their role is to plan and provide services for their local populations. The national primary care plan requires health boards to prioritise the rapid development of the clusters in their area.
- 7 To support the national primary care plan and encourage innovation, the Welsh Government introduced the national primary care fund in 2015-16. And in 2016-17, the fund totalled £41 million. Cluster development was provided with £10 million and health boards were allocated £3.8 million for pathfinder and pacesetter projects, which aimed to test elements of the primary care plan. The projects funded in this way have produced some new ways of working that have been collated into the Transformational Model of Primary and Community Care⁴.
- 8 Since the national primary care plan was published in 2014, there have been several developments. In October 2017, the National Assembly's Health, Social

² NHS Wales. Planned Primary Care Workforce for Wales: Approach and development actions to be taken in support of the plan for a primary care service in Wales up to 2018. July 2015.

³ Welsh Government. Setting the Direction Primary & Community Services Strategic Delivery Programme. 2009.

⁴ <http://www.primarycareone.wales.nhs.uk/pacesetters>

Care and Sport Committee published a [report](#) following their inquiry into clusters⁵. The report noted impressive examples of progress but said that a step-change is required if clusters are to have a significant impact. The Welsh Government has continued to support the cluster approach through its programme for government⁶.

9 However, at the same time as health boards are introducing new ways of working in primary care, there have been difficulties with recruitment and retention of GPs and other professionals. While there have been recent successes in recruiting GP trainees⁷, in many areas more GP partners are retiring and there are particular difficulties in recruitment in rural areas.

10 The Welsh Government is planning to respond to the Parliamentary Review of Health and Social Care in Wales⁸ with a £100 million transformation fund. It will be used to improve population health, drive integration of health and care services, build primary care, provide care closer to home, and transform hospital services.

11 It is timely for the Auditor General to review primary care services in Wales. We have published two national reports on primary care this year. In April 2018, we published [A picture of primary care in Wales](#). This provides a factual snapshot of primary care in Wales and contains background information that is not detailed in this report. And in July 2018, we published [Primary care out-of-hours services](#).

12 This report summarises the findings of work in Hywel Dda University Health Board (the Health Board) carried out between March and May 2018. The audit considered whether the Health Board is well placed to deliver the national vision for primary care as set out in the national plan. [Appendix 1](#) shows our methods. The work focused specifically on:

- **Strategic planning:** Is the Health Board effectively driving implementation of the national primary care plan at a local level?
- **Investment:** Is the Health Board managing its finances to support transformation in primary care?
- **Workforce:** Is the Health Board well placed to deliver key aspects of the national primary care workforce plan?
- **Oversight and leadership:** Does the Health Board have effective arrangements for oversight and leadership that support transformation in primary care?

⁵ National Assembly for Wales, Health, Social Care and Sport Committee. Inquiry into Primary Care: Clusters. October 2017.

⁶ Welsh Government. Prosperity for All: the national strategy. September 2017.

⁷ The Welsh Government reported that 91% of Wales' GP training places were filled in 2017. 16 October 2017. <http://gov.wales/newsroom/health-and-social-services/2017/gprecruitnew/?lang=en>

⁸ The Parliamentary Review of Health and Social Care in Wales. A Revolution from Within: Transforming Health and Care in Wales. Final Report. January 2018.

- **Performance and monitoring:** Is the Health Board effectively monitoring its performance and progress in implementing its primary care plan?

Key findings

- 13 Our overall conclusion is: **The Health Board has ambitious plans for primary care and is taking steps towards implementing key aspects of the national vision. However, financial pressures are making it difficult to redirect funds to primary care, workforce challenges are threatening the sustainability of services and national performance levels are generally worse than the rest of Wales.**
- 14 **Exhibit 2** sets out our key findings in more detail.

Exhibit 2: our main findings

Our main findings
<p>Strategic planning: The Health Board’s plan aligns with the national vision and is supported by cluster plans but there is scope for more detailed financial planning and improved consultation.</p> <ul style="list-style-type: none"> • The Health Board has an ambitious plan for primary care that aligns with the national plan although there is scope improve consultation and a lack of detailed financial planning. • All clusters have plans that support the Health Board’s vision, although cluster maturity varies, and cluster leads highlighted scope to improve the support provided by the Health Board.
<p>Investment: There has been some progress in shifting resources to primary care, but financial pressures are a barrier. There are mixed views on the effectiveness of the Health Board’s monitoring of cluster spending</p> <ul style="list-style-type: none"> • The format of the accounts makes it difficult to accurately calculate the Health Board’s overall investment in primary care. • The Health Board can point to some specific examples of shifting resources towards primary care but has not quantified the total resource shifted and financial difficulties are complicating efforts to redirect funds to primary care. • The Health Board closely monitors cluster spending and whilst most cluster leads felt they had enough financial autonomy, some felt the level of monitoring slowed decision making. • The Health Board has been increasing its investment in primary care premises improvement grants and has recognised the need for a standalone primary care estates strategy.
<p>Workforce: Workforce challenges threaten the sustainability of primary care and while the Health Board is in the early stages of testing out solutions, there are barriers to the further development of new ways of working</p> <ul style="list-style-type: none"> • The Health Board has mapped its primary care workforce and whilst there are gaps in the data, analysis suggests a shortfall in GPs and nurses, an ageing workforce and increase list sizes. • The Health Board’s primary care workforce plan sets out future staffing requirements in each locality but needs to be updated to reflect the Transforming Clinical Services programme. • The Health Board has increased the budget of its Primary Care Support Unit and the number of GP practices directly managed by the Health Board has increased from two to three.

Our main findings

- The Health Board has made some progress with implementing multi-professional primary care teams but there are some barriers to their further development including funding issues, delayed processes and limited evaluation of successful schemes.

Oversight: The Health Board's leaders are experienced in primary care, performance is monitored at various levels and while primary care is increasing in profile, it is a lower priority than secondary care

- Members of the Board and Executive Team are experienced in leading primary care and while primary care is increasing in profile, it is still seen as a lower priority than secondary care.
- Primary care performance and risks are reviewed at various levels, but monitoring is hampered by a lack of data on some key aspects of primary care.
- GPs provide leadership to most clusters and these leads gave positive views about the Health Board's oversight, although there are concerns about the time available to lead the clusters.

Performance: Performance against national targets remains below the rest of Wales in many areas and some difficult challenges remain

- Many aspects of the Health Board's primary care performance against national targets are worse than the Welsh average.
- A number of challenges remain including recruitment and retention issues, difficulties shifting resources, financial pressures and increasing demand.

Recommendations

- 15 As a result of this work, we have made a number of recommendations which are set out in [Exhibit 3](#).

Exhibit 3: recommendations

Recommendations

Strategic planning

- R1 The Health Board's plans for primary care have been developed with only limited consultation and collaboration with some key groups of stakeholders. The Health Board should therefore develop the necessary consultation and communications plans to ensure meaningful public and stakeholder engagement in any further development / refinement of its primary care plans.
- R2 The Health Board's plans for primary care are not supported by detailed financial analysis meaning it is unclear how the implementation of the plans will be funded. The Health Board should therefore develop clear a financial cost analysis to support its primary care plans to ensure its plans are affordable and to set how it will fund any planned changes.

Investment in primary care

- R3 While the Health Board recognises that it needs to shift resources from secondary to primary and community settings, it cannot demonstrate that this shift is happening. The Health Board should:

Recommendations

- a) Calculate a baseline position for its current investment and resource use in primary and community care.
- b) Review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care.

Oversight of primary care

- R4 We found scope to improve the way in which primary care performance is monitored and reported at Board and committee level. The Health Board should:
- a) Ensure the contents of its Board and committee performance reports adequately cover primary care.
 - b) Increase the frequency with which Board and committees receive performance reports regarding primary care.
 - c) Ensure that reports to Board and committees provide sufficient commentary on progress in delivering Health Board plans for primary care, and the extent to which those plans are resulting in improved experiences and outcomes for patients.

Primary care workforce

- R5 The Health Board's workforce planning is inhibited by having limited data about the number and skills of staff working in primary care. The Health Board should:
- a) Develop and implement an action plan for ensuring it has regular, comprehensive, standardised information on the number and skills of staff, from all professions working in all primary care settings.
 - b) Revisit its primary care workforce plans to ensure they take account of the issues arising from the Transforming Clinical Services programme.

Primary care clusters

- R6 We found variation in the maturity of primary care clusters, and scope to improve cluster leadership. The Health Board should:
- a) Review the membership of clusters and attendance at cluster meetings to assess whether there is a need to increase representation from local authorities, third sector, lay representatives and other stakeholder groups.
 - b) Encourage all cluster leads to attend the Confident Primary Care Leaders course.

New ways of working

- R7 Whilst the Health Board is taking steps towards implementing some new ways of working, more progress is required to evaluate the effectiveness of these new models and to mainstream their funding. The Health Board should:
- a) Work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models.

Recommendations

- b) Subject to positive evaluation, begin to fund these new models from mainstream funding, rather than from the Primary Care Development Fund.
- c) Work with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce demand for GP appointments.

Detailed report

Strategic planning: The Health Board's plan aligns with the national vision but there is scope to for more detailed financial planning and improved consultation

The Health Board has an ambitious plan for primary care that aligns with the national plan although there is scope improve consultation and a lack of detailed financial planning

The Health Board has an ambitious plan for primary care as part of a vision for transferring care and services to the community

- 16 The Health Board has articulated its plans for primary care in the following documents:
 - Primary Care Vision document (January 2018);
 - Transforming Clinical Services (TCS) Phase 1 (November 2017);
 - Draft Interim Annual Plan V3.1 (April 2018); and
 - Primary and Community Care Action Plan dated (December 2017).
- 17 The TCS strategy is the overarching strategy, which will drive healthcare development within Hywel Dda. The aims of the TCS strategy are to improve:
 - Quality of care;
 - Meeting the changing needs of patients;
 - Making our resources go further; and
 - Joining up services.
- 18 To achieve these aims, the Health Board plans to make fundamental changes to the way it delivers 'out of hospital' care, 'urgent and emergency' care and 'planned' care.
- 19 The TCS strategy recognises that care provided 'out of hospital' includes support given by 'GPs, district and community nurses, pharmacists, opticians, dentists, occupational therapists, podiatrists, speech and language therapists, dieticians and others. It also includes services delivered in the community by clinicians who are usually based in hospital, and social care provided by the local authority and voluntary sector services'.
- 20 The Primary Care Vision has evolved over the past 3 years and considers both local initiatives, such as the TCS process and the Wales Government (WG) national plan for primary care. There is evidence of cluster involvement in the planning process. Progress is monitored through Locality meetings and the Primary Care Sub-Committee.

- 21 Primary and community care services are currently provided across the three counties that make up the Health Board area - Carmarthenshire, Pembrokeshire and Ceredigion - in seven localities. The main drive of the Primary Care Vision is to develop General Medical Services 'Hubs' within localities following a pilot in three locations in 2018-19.
- 22 Our fieldwork has confirmed that several cluster schemes have been planned and implemented successfully. The TCS process has made the strategy for primary care clearer as it confirms the need to transform 'out of hospital care'. TCS defines 'out of hospital care as '... including support given by GPs, district and community nurses, pharmacists, opticians, dentists, occupational therapists, podiatrists, speech and language therapists, dieticians and others. It also includes services delivered in the community by clinicians who are usually based in hospital, and social care provided by the local authority and voluntary sector services'.
- 23 The current Primary Care Vision is inclusive of a wide range of primary care staff and is not limited to General Practitioners and General Medical Services. This inclusiveness is seen as essential for sustainable change to be implemented.

We found a number of strengths in the Health Board's primary care plans, including alignment with the national plan but weaknesses include a lack of financial detail

- 24 We reviewed the Health Board's plan for primary care to assess whether it contained key elements that ensure alignment with the national primary care plan and transformational model. Overall, the consensus of those that we spoke to was that the Health Board's plans for primary care are strong. They are, however, ambitious and require close monitoring to ensure successful implementation.
- 25 We found that there were a number of areas in the Health Board's plan that highlight strengths:
- there is a clear vision for transforming primary care based on local health needs assessments;
 - the plan makes specific reference to the national transformational model and there are plans to develop the capacity and capability of clusters;
 - the plan includes the intention to engage with the public in future planning of services;
 - the plan identifies how technology will be used effectively to support services;
 - workforce plans have been developed to take account of current and known future service requirements;
 - the plan integrates with other Health Board plans and strategies; and
 - there is an agreed process for monitoring the implementation of the Annual Operating Plan. Governance arrangements are in place to monitor the Primary Care Plan through the Primary Care Sub Committee, Locality and Cluster meetings.

- 26 We also found areas of the Health Board's plans that need further attention:
- key schemes, such as the development of Hubs, is dependent on the availability of pacesetter funding. This funding was not confirmed at the time of our review.
 - the financial plans provided by the Health Board at the time of our review lack detail on the financial implications of the plan. This begs questions about how resources will shift from secondary to primary care, how the allocation from the Welsh Government's Primary Care Development Fund will be used and how other innovation funding be spent.
 - there is no estates strategy for primary care (although the Health Board intends to develop this as part of the TCS process).
 - the IMTP does not outline the arrangements for the leadership of transformation in primary care. There is no reference in the IMTP about how the required changes will be led or how progress will be monitored.
- 27 Interviewees told us about concerns relating to the scale of the changes required against the backdrop of the Health Board's difficult financial position. We also found that the TCS process is dependent on public consultations, the outcome of which may impact the successful implementation of the plan.

The Health Board engages with stakeholders on primary care, but some partners feel that this engagement is not collaborative enough and want to be engaged earlier in the process

- 28 It is important for the health board to collaborate with stakeholders in developing their primary care plans. The Health Board has engaged with a wide range of both internal and external stakeholders. This includes patients, the Community Health Council, third sector other NHS bodies, local authorities and some professional groups.
- 29 However, our fieldwork has highlighted that some groups feel that engagement has been limited to a presentation of plans rather than an exchange of ideas. Some interviewees also told us that engagement tends to be at a late stage in the production of plans.
- 30 The launch of the TCS programme is an opportunity of the Health Board to review its arrangement for engaging with stakeholders when developing service plans.

All clusters have plans that support the Health Board's vision, although cluster maturity varies, and cluster leads highlighted scope to improve the support provided by the Health Board

- 31 We looked at the way that the board provides support to clusters in developing local needs assessments and plans. We found that all clusters have a cluster plan, and all have undertaken a needs assessment of their local population. As part of our fieldwork we conducted a survey of cluster leads. This survey was carried out in April 2018. Most cluster leads who responded to our survey (4 out of 5) said that they have received support from the Health Board to develop their needs assessments.
- 32 Of the five respondents, a minority (2 out of 5) agreed that they received helpful guidance from the Health Board in developing their cluster plans. However, none of the cluster leads who completed the survey, agreed that they are listened to when developing health board level priorities for primary care.
- 33 Each cluster has access to a Locality Lead and full-time support from a Locality Development Manager who provides leadership, organisational and administrative support. The Locality Development Manager takes the lead on supporting practices to complete their plans and this information is used to develop a cluster-wide plan.
- 34 Additional support for cluster planning is provided by a Practice Manager Lead, as well as community pharmacy, general dental and community optometry leads. Clusters are also supported by corporate departments such as Public Health (particularly around needs assessment), Finance, IM&T and senior Primary Care managers. The level of support available to each cluster varies.
- 35 The maturity of the clusters remains variable. Not all clusters reported having local authority or third sector representation and none reported having lay representatives. Furthermore, most clusters (4 out of 5) report being at a stable stage of organisational development with 'ongoing support required and full potential yet to be reached'. Only one cluster assessed themselves as being 'mature' with all members fully engaged ([Exhibit 4](#)).

Exhibit 4: Cluster leads' assessment of the level of their organisation's development

	1 = Developmental	2 = Stable and starting to deliver	3 = Mature
Abertawe Bro Morgannwg	1	4	2
Aneurin Bevan	1	6	0
Betsi Cadwaladr	2	5	1
Cwm Taf	0	5	2
Cardiff and Vale	1	5	2
Hywel Dda	0	4	1
Powys	1	1	1
Wales	6	30	9

Note:

1 = Developmental: still at early stages of development with significant support required; not all cluster members fully engaged.

2 = Stable and starting to deliver: Starting to deliver some benefits but still early days, ongoing support required and full potential yet to be reached.

3 = Mature: all cluster members fully engaged; delivering across a number of areas in line with the cluster plan.

Source: Wales Audit Office survey of cluster leads, April 2018

36 Our survey of cluster leads highlighted some concerns about the maturity of clusters. Comments received included the following:

- despite some progress there have been sustainability problems in clusters, which have had a knock-on effect and made some practices more inward looking and defensive;
- the above has resulted in benefits of joint working across the cluster not being realised; and
- more lay representation in clusters would provide a useful challenge and resource.

Investment: There has been some progress in shifting resources to primary care, but financial pressures are a barrier. There are mixed views on the effectiveness of the Health Board's monitoring of cluster spending

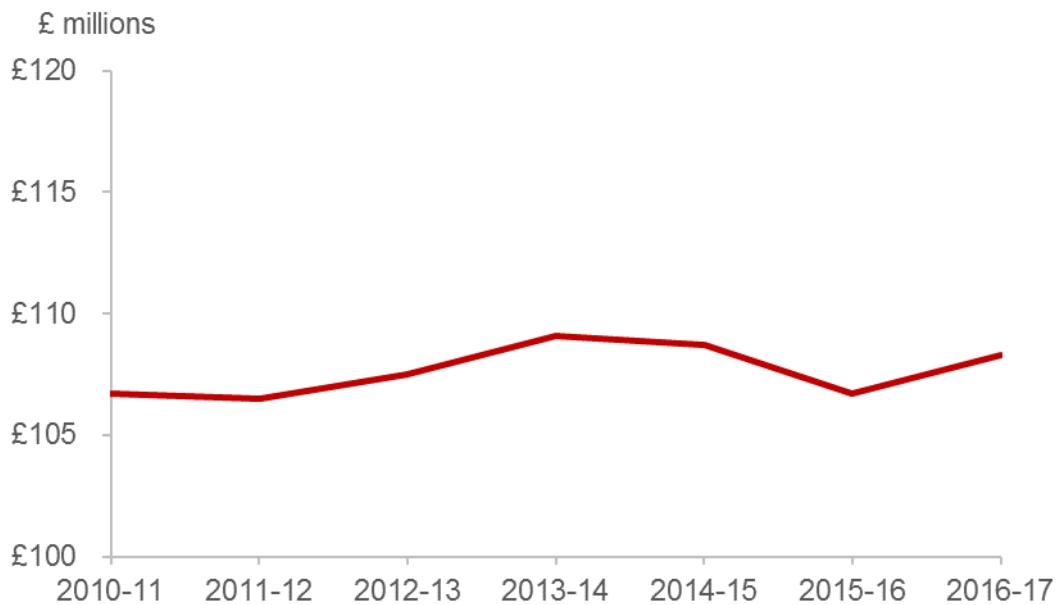
The format of the accounts makes it difficult to accurately calculate the Health Board's overall investment in primary care

- 37 The Welsh Government allocates money to health boards in a range of primary care categories. In 2016-17, the Health Board spent more than its allocation on General Medical Services (GMS) (+£0.4 million)⁹ and less than its allocation on Pharmacy Services (-£7 million) and General Dental Services (-£2.6 million).
- 38 The Health Board has consistently spent above the allocation it has received from Welsh Government for GMS. The Health Board told us this is mainly due to the cost of out of hours services being more than the allocation they receive.
- 39 **Exhibit 5** is based on data from the Health Board's annual accounts and sets out the Health Board's long-term, overall expenditure on primary care. The total includes spending on General Medical Services, Pharmaceutical Services, General Dental Services, General Ophthalmic Services and 'Other' Primary Health Care Expenditure¹⁰. The exhibit shows that in cash terms, overall expenditure on primary care has increased slightly (+1.5%) from £106.7 million in 2010-11 to £108.3 million in 2016-17.

⁹ The 2016-17 GMS expenditure was reduced on a non-recurring basis by the receipt of a £3.7 million rate rebates. Without this adjustment, expenditure would have been £64.6 million. There was no inflationary uplift to GMS allocation in 2016-17 as Health Boards were expected to offset it against the rate rebate. The allocation adjustment subsequently actioned in 2017-18 was £1.6 million.

¹⁰ Excludes spending on 'Prescribed drugs and appliances'.

Exhibit 5: the Health Board's spending on primary care services



Note: We have excluded expenditure on 'Prescribed drugs and appliances' due to variable nature of this expenditure resulting from drug price fluctuations

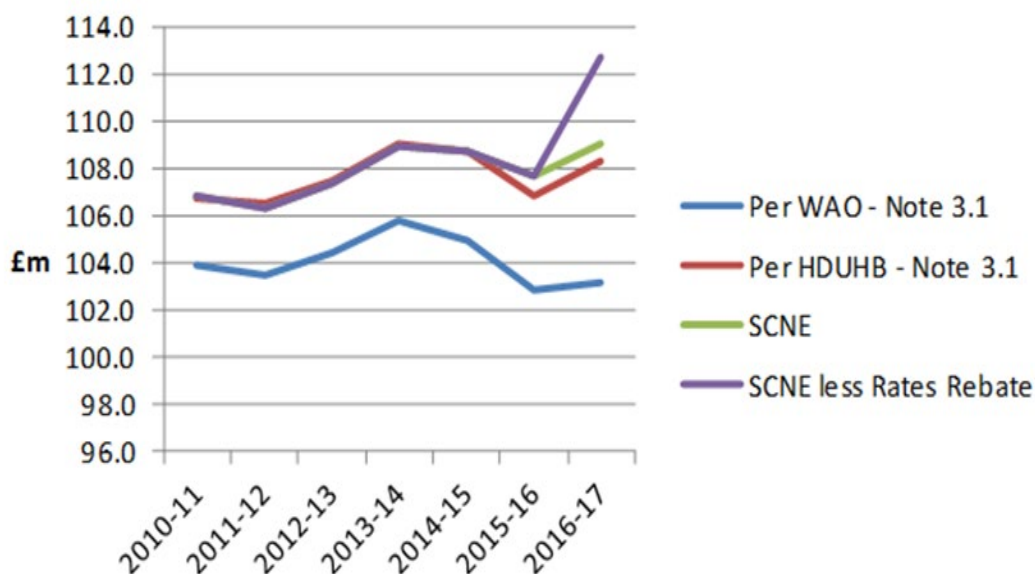
Source: LHBs Annual Accounts

- 40 The Health Board received funding to develop projects in support of the pacesetter programme that aim to test elements of the primary care plan. Projects included in the Pacesetter Programme were support to staff and clusters to work together in designing & delivering alternative models of primary care. Also, funding was made available for a Primary Care Support Unit to develop a Multi-Disciplinary Team to support practice and cluster development. Following evaluation and assuming the continuation of Welsh Government support, a bid was made in February 2018 for funding for the further development of a networked model for Primary Care.
- 41 After considering the effect of inflation, the Health Board's overall spending on primary care¹¹ decreased in real terms by 7.5% between 2010-11 and 2016-17. However, across Wales we found issues with the way that primary care expenditure is recorded in the accounts. Spending is not consistently categorised by health boards and the figures recorded in the accounts often do not represent the totality of primary care expenditure.

¹¹ Including General Medical Services, Pharmaceutical Services, General Dental Services, General Ophthalmic Services and 'Other' Primary Health Care Expenditure.

42 Partly due to the issues mentioned in the paragraph above, and because of issues explained further at [Appendix 2](#), the Health Board has disputed the figures included in Exhibit 5. The Health Board argues that a better source of information to determine expenditure on primary care would be the Statement of Comprehensive Net Expenditure (SCNE) used to produce the monitoring returns. If this method was used, then expenditure on primary care would be as set out in [Exhibit 6](#).

Exhibit 6: the Health Board has provided an alternative set of data on primary care spending



Source: LHB Self-Assessment

The Health Board has some specific examples of shifting resources towards primary care but has not quantified the total resource shifted and financial difficulties are complicating efforts to redirect funds to primary care

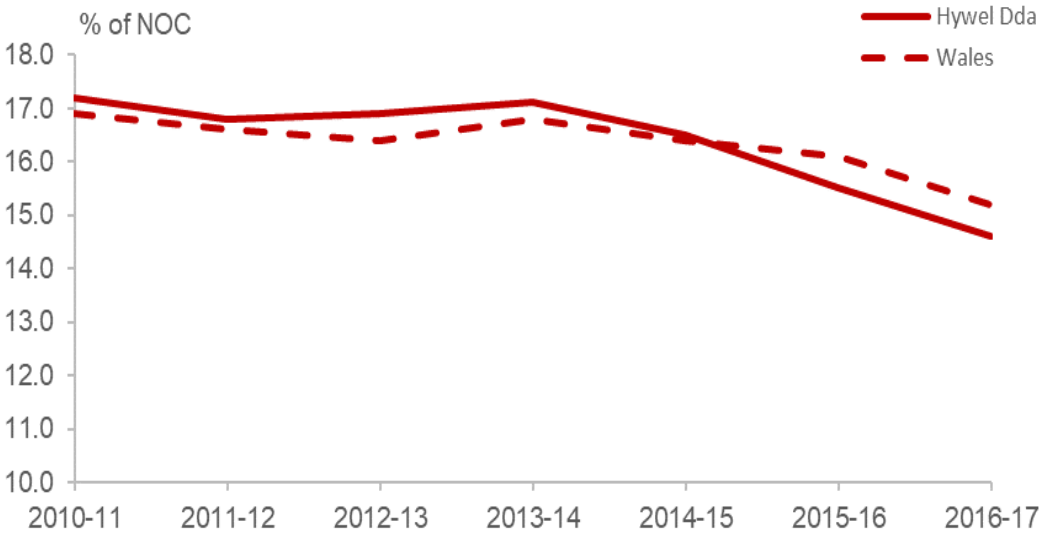
43 For many years, the NHS in Wales has planned to shift resources towards primary care, to reverse the ‘relative under-development of primary care’¹². The current national primary care plan again stresses the importance of ‘health boards moving their resources towards primary care’.

44 [Exhibit 7](#) shows the Health Board’s expenditure on primary care as a percentage of its total expenditure (Net Operating Cost, 2010-11 to 2016-17). The figures exclude expenditure on prescribed drugs and appliances. The exhibit shows that despite

¹² Welsh Government, *Improving Health in Wales: The Future of Primary Care*, July 2001.

national priorities for shifting resources towards primary care, across Wales as a whole, primary care spending has not kept pace with health boards' total spending. Expenditure on primary care as a percentage of the Hywel Dda's total expenditure (Net Operating Cost) was below the Wales average in both 2015-16 and 2016-17.

Exhibit 7: the Health Board's expenditure on primary care as a percentage of its total expenditure (Net Operating Cost, 2010-11 to 2016-17).



Source: LHBs' Annual Accounts

- 45 We asked whether the health boards are taking specific actions to achieve a shift in resources towards primary care. We found that none of the health boards have set targets for moving resources towards primary care.
- 46 The national primary care plan requires health boards to develop a priority list of secondary care services, which, in future it plans to deliver in primary or community settings. We found that whilst there was no priority list at the time of our review, the Health Board is developing a list of services to transfer to primary care. This is part of the ongoing TCS programme. It should be noted that, to date, some services such as anti-coagulation care, diabetes, and dermatology have already been transferred. However, our fieldwork has revealed that staff feel that secondary care access targets are the priority and that the current financial difficulties faced by the Board make it difficult to redirect funds towards primary care¹³.
- 47 We also asked health boards if they have quantified the total amount of resource moved towards primary care since the inception of the national primary care plan in

¹³ Against its statutory duty to achieve financial breakeven, the financial position at the end of April 2018 is a £5.626 million deficit.

2014. We found that none of the health boards has calculated a total of finances moved although the Health Board told us that they have examples of resources that have shifted to primary care from other areas. In addition to the examples above, the Health Board has invested Hospital and Community Health Service (HCHS) resources in Primary Care. Examples of this are out-of-hours services receiving HCHS investment over several years and the funding of excess costs of the Diabetes service.

The Health Board closely monitors cluster spending and whilst most cluster leads felt they had enough financial autonomy, some felt the level of monitoring slowed decision making

- 48 Health boards need to strike the right balance of giving autonomy to clusters whilst at the same time overseeing their spending. The Health Board's approach to overseeing cluster spending involves close monitoring. The Health Boards view is that, as the Board receives funding for primary care clusters from the Welsh Government then the Health Board is responsible for the stewardship of the resources and must ensure that they are properly accounted for. Cluster budgets are therefore controlled and monitored like all other budgets in the Health Board. Cluster budget holders must comply with the Health Board's Standing Orders and Standing Financial Instructions when dealing with these resources.
- 49 Budget holders receive monthly reports regarding their use of resources. The reports show annual budget, year-to-date (YTD) budget, projected annual expenditure, and year to date expenditure. Variances between budget and expenditure are highlighted and actions to resolve differences are reported. Budget holders meet their designated finance lead monthly to discuss the reports.
- 50 Despite this close financial monitoring the Health Board told us it tries to take a light touch with clusters to allow them to innovate and use the available resources in a way which best suits their population needs and assets.
- 51 All respondents to our cluster lead survey agreed (5 out of 5) that the Health Board effectively monitors cluster expenditure. Most respondents (4 out of 5) agreed that the Health Board gives their cluster sufficient financial autonomy, but most did not agree (3 out of 5) that the Health Board provides ongoing funding to successful pathfinder/pacesetter schemes.
- 52 Our fieldwork revealed that cluster leads feel this monitoring to be too close and driven by the Health Board's overall financial position which can lead to frustration at both the pace of decision making and to risk aversion. Some feel that the process for applying for pacesetter funding is not clear and that they receive no information on how the money is spent.
- 53 There is also concern from clusters that the current NHS financial regulations have not kept up with the pace of changes in primary care. It is felt that the current system is inflexible and does not allow for medium or longer-term planning

especially around recruitment of staff to permanent roles. An example given concerned the ability to roll over unspent allocations across financial years.

- 54 All respondents to our cluster lead survey (5 out of 5) agreed that their cluster spends all the funding that it receives and the majority (4 out of 5) agreed that their cluster can spend its funding quickly once it has been decided how to allocate it.

The Health Board has been increasing its investment in primary care premises improvement grants and has recognised the need for a standalone primary care estates strategy

- 55 In 2017, the Welsh Government announced support for the development of health and wellbeing centres with a capital value of around £68 million. For the Health Board it proposed three major developments, Aberaeron Integrated Care Centre, Fishguard Health Centre and Cross Hands Integrated Care Centre.
- 56 The Health Board has considered the estates implications of its primary care plans in the following ways. The Health Board's estates requirements have been referred to in its Primary Care Vision document. This recognises that there is a wide range of estate needs across the Health Board area and this needs to be considered based on the development of primary care model. The proposed hubs require sufficient space and a suitable environment to deliver team-based models of care.
- 57 The draft Interim Annual Plan echoes these thoughts as it states that plans need to be flexible enough to adapt to the changing needs and requirements throughout the interim period and will support the development of a detailed estates strategy in line with the TCS outcomes as it is developed.
- 58 There is no standalone primary care estates strategy. The Health Board's current plans represent a first stage approach in developing an estates strategy that will ultimately need to reflect and support the delivery of the TCS plans.
- 59 Health boards provide major and minor improvement grants to support the primary care infrastructure¹⁴. In the Health Board there has been increasing investment for Premises Improvement Grants. In 2015-16 total investment was £169,084, in 2016-17 this rose to £182,406 and in 2017-18 it increased again to £298,589.
- 60 The national primary care plan stresses the importance of effective, integrated ICT systems to support better use of information by the public and primary care professionals. The NHS Wales Informatics Service leads on most ICT developments related to primary care, but the Health Board has made several systems available to GP practices:
- **Welsh Clinical Communications Gateway (WCCG) – e-referrals.** This is available to all GP practices and 38% of all referrals are now electronic. All practices have received training and refresher training is available.

¹⁴ The National Health Service (General Medical Services - Premises Costs) (Wales) Directions 2015 (2015 No.9)

- **Electronic prioritisation of referrals.** Currently five specialties are prepared for electronic prioritisation. These include Dermatology, Rheumatology, Urology and Respiratory specialties. This means that referrals can be more speedily prioritised and appropriate appointments given. Work is ongoing to prepare the remaining specialties for e-referral on WCCG. This is expected to be completed by April 2019.
- **GP test requesting.** Available to all practices to enable them to obtain pathology reports quicker. Current usage is 8.5% of tests requested electronically. The system is not ready for further implementation due to print quality and the speed of the system. NWIS are currently introducing improvements and these will be tested before further implementation.
- **All Wales test results.** The Health Board has implemented the Welsh Results Repository Service. This provides access to results from other health boards for a practice patient.

Workforce: Workforce challenges threaten the sustainability of primary care and while the Health Board is in the early stages of testing out solutions, there are barriers to the further development of new ways of working

The Health Board has mapped its primary care workforce and whilst there are gaps in the data, analysis suggests a shortfall in GPs and nurses, an ageing workforce and increased list sizes

- 61 We assessed what health boards are doing to model the future capacity and skills they need in the primary care workforce. The Health Board undertook a primary care workforce review in 2016. However, it was difficult to collect data of sufficient quality and detail. In 2016-17, the Health Board employed an organisational development project officer, with a specific role of helping to improve understanding of primary care staffing data. This resource was not available in 2017-18 so updated data was not available the time of our review.
- 62 The project officer’s work produced the data shown in [Exhibit 8](#). It shows that as of 1 October 2017, the Health Board recorded practice clinical staff and predicted and aspirational appointments to 2021 as shown below. The final column indicates the additional staff required to achieve their vision of sustainable services. The data shows that 71.2 WTE additional GPs are needed to ‘future-proof’ service provision in the next five years.

Exhibit 8: predicted growth in staff numbers

Staff group	Total WTE 2016	WTE predicted & aspirational employments 2016-2021
GP	195.5	71.2
Advanced Nurse Practitioners & Nurse Practitioners	22.4	18.7
Practice Nurse	101.5	31.0
Advanced Practitioner	3.4	0
Specialist Nurse	6.7	6.9
Nurse Prescriber	2.9	2
Health Care Assistants	50.9	14.8
Phlebotomist	5.3	4.6
Dispenser	16.5	2
Pharmacist	1.6	1

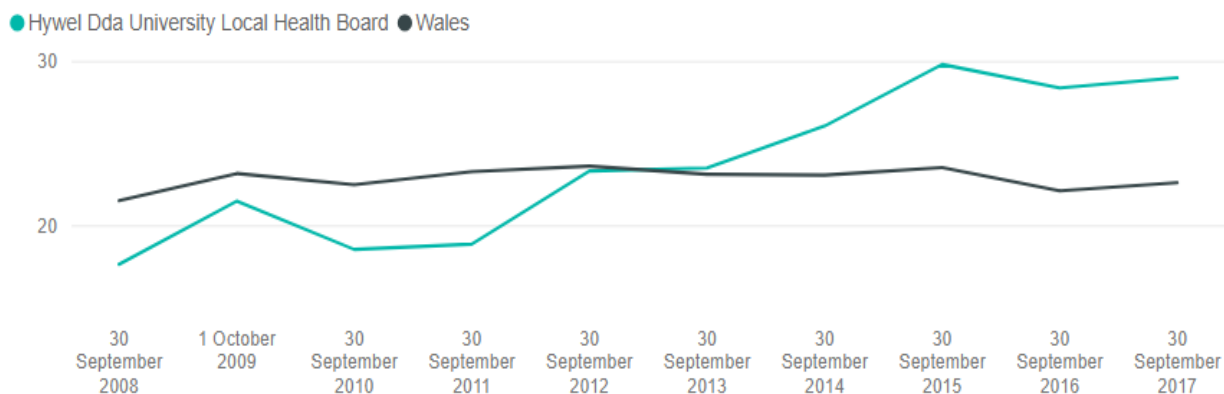
Note: Aspirational Employments are defined as new roles identified by practice where there is currently no one in post or an increase in hours of a current post

Source: Hywel Dda University Health Board

- 63 Modelling shows that more staff will be required to support future sustainability. The Health Board predicts that it will need 18.7 WTE more advanced nurse practitioners and nurse practitioners and 31 WTE practice nurses. Predictions also show that more specialist practice nurses will be needed (6.9 WTE) than are currently in post in general practice.
- 64 As these figures incorporate current vacancies, those eligible to retire and 'aspirational employments', the numbers indicate that practices are seeking to employ more nurse/specialist roles in the workforce. This reflects the Health Board's aim to introduce more 'alternative first points of contact' for patients. This shows that practices are trying to move away from replacing like-for-like and are trying to introduce new roles within primary care.
- 65 Considering the numbers needed to sustain traditional working versus the current numbers coming through, the Health Board is looking increasingly at how it can develop new ways of working/workforce models and role.
- 66 In addition to the analysis in [Exhibit 8](#), the Health Board has analysed the age profile of GPs and continues to gather data on the extent of GPs working part-time or full-time. It also collects data on the number and skill mix of all staff working in GP practices, including staff that work across more than one practice. This data is included in the GMS dashboard and discussed regularly at the Primary Care Sub Committee. No central data is available for staff working in community pharmacy, community dentistry or community optometry although for the latter, Optometry Wales is undertaking a workforce data collection exercise on behalf of Welsh Government and the results will be shared with health boards in due course.
- 67 Our fieldwork has indicated that there are staffing issues across the Health Board area and across a range of health professional disciplines including doctors, nurses, physiotherapists, pharmacists, dentists and paramedics. There are challenges in attracting new staff across all professional groups to work in the more rural areas of West Wales.
- 68 Staff shortages has led to increased competition between practices to attract and retain staff, particularly nurses and it is felt that the Health Board could assist by making primary care careers more attractive and breaking down some of the perceived barriers between primary and secondary care.
- 69 Our analysis of available data suggests the Health Board has issues with the age profile of its GPs and nurses. [Exhibit 9](#) shows that 29% of GPs in the Health Board area are aged 55 and over, compared to 22.6% in Wales as a whole.

Exhibit 9: percentage of GPs aged 55 and over

% of GPs Aged 55 and Over

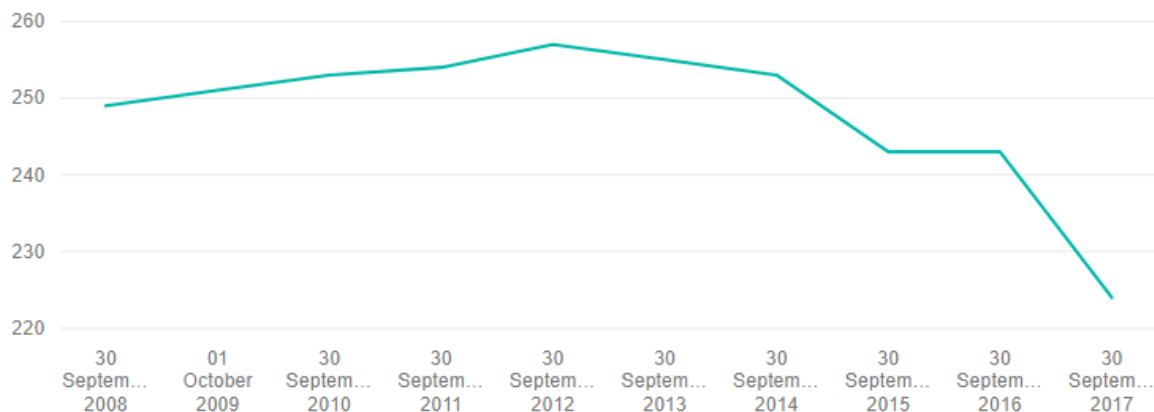


Source: Welsh Government

70 Exhibit 10 shows that the number of GPs has fallen from 243 in September 2016 to 224 in September 2017.

Exhibit 10: number of GP practitioners

GP Practitioners



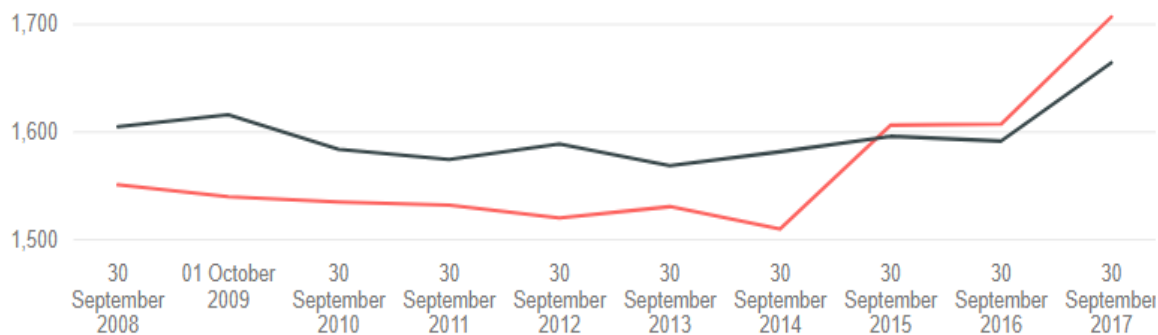
Source: Welsh Government

71 The reduction in the number of GPs has happened in parallel with an increase in average list size from 1,607 in September 2016 to 1,707, as shown in Exhibit 11.

Exhibit 11: average list size in the Health Board

Average List Size

● Hywel Dda University Local Health Board ● Wales



Source: Welsh Government

The Health Board's primary care workforce plan sets out future staffing requirements in each locality but needs to be updated to reflect the Transforming Clinical Services programme

- 72 The Health Board's Draft Annual Plan includes a section on workforce recruitment and development and identifies key areas of work for 2018-19. It contains an assessment of current workforce, the age profile, known current workforce risks and an assessment undertaken by primary care localities of potential future service workforce need. Below this level the Primary and Community Care Action Plan highlights the need to develop and grow the multi-disciplinary team capable of working together to deliver holistic services for the population and promote self-care and well-being.
- 73 The Health Board's Primary Care Workforce Plan contains analysis of staffing issues in each of the seven localities. This is important as each locality has different needs for its population and different models for service provision based on geography and available providers. We have reported the results of the analysis of the primary care workforce above.
- 74 The objective of the workforce plan is to strengthen the information on the current workforce model whilst also identifying the workforce risks and actions needed for the future sustainability and development. The Health Board is using this to inform the main Workforce and Organisational Development Action Plan. The Health Board is planning a further review of staffing as part of the Transforming Clinical Services Programme.

The Health Board has increased the budget of its Primary Care Support Unit and the number of GP practices directly managed by the Health Board has increased from two to three

- 75 Many health boards have developed primary care support units, although the names and functions of these units vary across Wales. The budget dedicated to the unit in the Health Board has increased from £338,320 in 2015-16 to £416,751 in 2017-18 and its main responsibilities are to support:
- the planning, developing, implementing and when required, delivering core GMS services in managed and independent GP practices.
 - practices that are having difficulties with workforce, and or service delivery/maintaining business and continuity planning.
 - the development of new models of service delivery in line with Welsh Government policies/plans and cluster plans.
 - the delivery of the Health Boards sustainability programme through the development of risk assessments, practice development and workforce planning. The Unit will also contribute towards an 'evidence base' to demonstrate the benefits of new roles in primary care and the wider care system.
- 76 The performance of the Primary Care Support Unit is monitored at the Primary Care Sub Committee and a progress report on the Primary Care Support Unit was made to the Welsh Government as part of the Delivery Agreement for the period October to December 2017. This reported on the progress and benefits of the support unit including achievements and emerging issues.
- 77 The Health Board uses the national GP Sustainability Assessment Framework to target support to struggling practices. As part of the GMS Quality and Outcomes Framework for 2017-18, all practices were required to undertake a self-assessment against the sustainability matrix to be submitted to the Health Board.
- 78 Work has commenced with the Primary Care Support Unit Manager and Primary Care Quality Manager to coordinate visits to serve both sustainability and quality purposes to practices that appear to need support/guidance from both areas. Sustainability tools that have been developed and a primary care 'heat map' is updated bi-monthly and included in the performance monthly report to the Primary Care Sub Committee. Practices that score poorly are offered a Sustainability and Support Visit from the Primary Care Support Unit
- 79 The number of practices directly managed by the Health Board increased from two to three in October 2017. This was necessary due to sustainability issue within the practice and the 'handing back' of the contract. This was precipitated by one of the three partners planning to relocate overseas and the remaining two partners feeling that they could not continue.

The Health Board has made some progress with implementing multi-professional primary care teams but there are some barriers to their further development

The Health Board has made some progress in establishing alternative first points of contact, but progress varies by cluster and more needs to be done to promote these new points of contact to patients

- 80 The national plan says that, in future, the role of GPs will be to provide overarching leadership of multi-professional teams. These teams would include pharmacists, therapists, optometrists, paramedics, advanced practice nurses and others. The national workforce plan says that health boards must find opportunities for these professionals to improve access by providing the first point of contact for patients.
- 81 Health Boards are using the Transformational Model of Primary and Community Care to further develop their own primary care plans using Pacesetter and Delivery Agreement projects from across Wales. Examples within Hywel Dda include the development and implementation of telephone consultations and triage, remotely supporting managed practices and those with sustainability issues.
- 82 The Health Board have also developed new roles within GP Practices such as Occupational Therapy, Physiotherapy, Clinical Pharmacists and Advanced Paramedic Practitioners. Locality Projects include social prescribing and 'community connectors' in North Pembrokeshire and Llanelli. They have developed a proactive frailty services utilising an MDT (Multi-Disciplinary Team) and a 'risk stratification' approach in South Ceredigion and Tywi/Taf.
- 83 The Health Board has made some progress in establishing alternative first points of contact for patients, as summarised in the bullet points below:
- direct referral to a physiotherapist for musculoskeletal patients in managed practices;
 - advanced practitioner paramedic clinics and a house visit service in managed practices, and some other practices where this service has been deemed necessary;
 - medicines management outreach services with pharmacists providing GP support. Clinical pharmacists have been employed in all Clusters and directly in many individual practices;
 - occupational therapists in Pembrokeshire prevent hospital admissions and are improving access in Primary Care;
 - physician Associates have been piloted in North Ceredigion; and
 - information on new roles and opportunities shared with contractors to enable them to consider alternative approaches to workload management.
- 84 The results of our cluster lead survey also suggested that clusters have made some progress in introducing new first points of contact, but this has been variable.

Half (2 out of 4) of the respondents said they have cluster pharmacists and were looking to employ a range of other staff including occupational therapists, advanced nurse practitioners and physiotherapists. The cluster survey also highlights progress made regarding pharmacist support and home visiting by paramedics. However, one cluster reports that they have made no progress.

- 85 Testing of these new roles will help the Health Board to understand the future workforce model it requires for primary care. The Health Board feels that that this work has enabled it to better understand the GMS workforce. However, because of the lack of data available, there is still more to do around the other contractor professions to have a fuller picture of what can be achieved in the future.
- 86 Our fieldwork has indicated that the Health Board needs to do more to publicise alternative first points of contact so that these are seen as a way of improving access to services and not about saving money. Interviews with staff suggest that patients are happy with alternative first points of contact once they have experienced them.
- 87 Our survey also shows that only half of the respondents agree that they have received funding directly to employ staff such as physiotherapists or pharmacists. Only 2 agree with the statement that their cluster has received funding in a timely way to employ staff and only 1 agrees that the Health Board is supporting their Cluster to recruit staff or support the cluster by directly employing staff on behalf of the cluster. Similarly, most (4 out of 5) disagree that their Cluster has plans for longer term funding of staff.

There are some examples in the Health Board of progress towards implementing enhanced multidisciplinary teams although there are complications related to training

- 88 The Transformational Model highlights the importance of enhanced multi-disciplinary teams (MDTs). The model stresses the need for these teams to provide a shared resource for all practices in a cluster. Progress within the Health Board includes:
- implementation of frailty MDT programmes within clusters. These have been designed to fit with the Health Boards frailty pathway and there are proposals to extend the model in the future, subject to available resources.
 - introduction of new roles to the MDT. This is working well, particularly for paramedics, physiotherapists, pharmacists and occupational therapists.
- 89 Our fieldwork revealed a need for more training for primary care staff to create effective MDTs, both for staff to be able to develop MDTs and their professional role within the team. However, the geography of the Health Board makes training difficult as it often needs to be repeated in several areas. This has cost and time implications.
- 90 The Transformational Model also highlights the need for shared systems of triage for members of multidisciplinary primary care teams. The main area of progress in the Health Board related to shared triage is in commissioning a remote telephone

consultation service for its three managed practices. The service, called GP Hub Wales, provides:

- a remote telephone GP consultation and triage support service which aims to improve primary healthcare access within GP practices. Each practice has a total of 30 patient contacts per day available to book. This is comparable to a whole time GP working within a practice;
- full secure access by the GPs working for the Hub to the practices' electronic systems, patients' notes, hospital letters etc., exactly as if they were working in the practice;
- the ability for the remote Hub GPs to manage prescriptions by creating the prescription and saving them to the system. The reception team in the local surgery is responsible for printing prescriptions and the surgery GP is responsible for the timely signing of the prescriptions; and
- facilities for the referral letters to be typed up by the remote Hub GP in the consultation notes which the reception staff can then send on following referral protocols.

Barriers to implementing new ways of working include funding issues, delayed processes and limited evaluation of successful schemes

91 Our work has revealed a number of barriers to implementing new ways of working in primary care. These barriers are summarised in the bullet points below:

- **Short-term funding for clusters** – Clusters are provided with annual funding. Without longer-term funding cycles, some clusters feel their ability to recruit high calibre staff is hampered.
- **Delays in Health Board recruitment processes** – Our fieldwork suggests that processes for agreeing staffing and recruitment are prolonged. Some consider that budgets are notified to clusters agreed late in the financial year, which leaves little time for the recruitment to take place.
- **Lack of evaluation** – Only two out of five cluster leads that responded to our survey agreed that the Health Board empowers them to drive innovation in primary care. Only one agreed that the Health Board effectively evaluates innovation in their area. It is felt that this is due to financial constraints. Also, communication of success is limited which prevents projects from being adopted and spreading to other areas. This can result in clusters' appetite for innovation stagnating.
- **Budgetary constraints** – Primary care partners often see it as unreasonable to develop services that have traditionally been the responsibility of secondary care, e.g. primary care counselling service. The barrier is moving budgets from secondary care to ensure that funding follows the patient.

- **Reluctance to innovate** – Some practices are reluctant to try new ways of working, but willingness can increase when their services are close to crisis. This means innovation is happening when staff are at their most unsettled.

Oversight: The Health Board’s leaders are experienced in primary care, performance is monitored at various levels and while primary care is increasing in profile, it is a lower priority than secondary care

Members of the Board and Executive Team are experienced in leading primary care and while primary care is increasing in profile, it is still seen as a lower priority than secondary care

- 92 To transform primary care, health boards need clear and effective arrangements for oversight and senior leadership. The vice chairs have a specific responsibility for championing primary care issues. At the Health Board we found that there is a range of primary care expertise at Board level, including the Chair who is an ex-Director of Primary, Community and Mental Health Services at the Health Board. The vice chair is also ex-NHS Assistant Chief Executive with experience of workforce development across all sectors. The Vice Chair takes an active, visible, interest in primary care issues and, as part of her role, is Chair of the Primary Care Applications Committee.
- 93 Across Wales we found slightly varying arrangements between health boards in the executive-level responsibilities for primary care. At the Health Board we found that there is a range of primary care expertise amongst the Executive Team. The Chief Executive has a background as a chief executive in a primary care trust and the Executive Medical Director has previously worked as an executive director of primary care, community and mental health services.
- 94 The main executive level responsibility for primary Care at the Health Board rests with the Director of Primary, Community and Long-Term Care. The current post holder has experience of primary care having previously been the Deputy Director of Primary Care, Community and Mental Health and Long-Term Care at the Health Board. She is an ex-Director of Nursing. She is supported in her role by a senior Deputy Director.
- 95 We examined the frequency with which the Board and sub committees consider agenda items related to primary care. We found that there are regular items on the main Board agenda related to primary care. In the period March 2017 to May 2018 there was at least one item on each Board agenda related to primary care, usually in the form of a county-wide report.

- 96 Despite this, interviewees told us that secondary care still dominates the Board agenda and that secondary care targets are seen as more important than primary care.
- 97 Discussions on Primary care take place at the bi-monthly Primary Care Sub Committee (PCSC). Our review of the Agenda for the PCSC shows that a wide range of issues are discussed including items on General strategy and integration, audit, performance and risk, and transforming clinical services. The committee has a wide representation of operational, corporate and medical staff. Decisions are recorded in the minutes and an Action Log is produced and monitored.
- 98 While there is some frustration at the pace of change, some interviewees told us that the Transforming Clinical Services programme is helping to rebalance the focus across primary and secondary care.
- 99 Our fieldwork suggests that the Health Board could be doing more to persuade its staff and outside bodies that primary care is as important a priority as other service areas. None of the cluster leads that responded to our survey agreed that the Health Board gives sufficiently high priority to transforming primary care.

Primary care performance and risks are reviewed at various levels, but monitoring is hampered by a lack of data on some key aspects of primary care

- 100 The Health Board produces reports on primary care performance that are considered within the committee structure. These reports include the Primary Care Quality and Performance Assurance Report and the Primary Care Finance Report.
- 101 In addition, there is the Integrated Performance Assurance Report, which is reported to the main Board monthly. The report is felt to be biased towards secondary care but does include primary care performance indicators related to:
- Patient satisfaction rates with GP services;
 - Training of GP practice teams (ie Mental health training in dementia);
 - Out of hours services;
 - 111 services;
 - Waiting times for therapies;
 - GP practice opening times; and
 - GP 'did not attend' rates.
- 102 During our fieldwork, staff told us that information on performance and activity could be improved, and currently fixates on surgery opening times. They feel that the current IT systems do not allow for the production of robust data due to a perceived lack of investment in IT systems in primary care. The IT systems that are available are not linked to each other as many are 'stand-alone' systems within practices. This makes consistent reporting between clusters difficult. Also, information on workforce is not robust as primary care staff are not included in the

Electronic Staff Record. Other weaknesses in monitoring include a lack of data related to outcomes, performance linked to population needs and cost benefit analyses. At the time of drafting our report, the Health Board was developing a primary care dashboard to incorporate all primary care indicators.

- 103 The Health Board has considered the risk to delivery of its primary care plans. There is a Primary Care Risk Register, which is reported to the Audit and Risk Assurance Committee, a subcommittee of the Board. This register is also reported to the Primary Care Sub Committee, as well as the Three Counties Primary and Community Care Quality and Safety Committee. Each risk has a control measure, an associated action plan and where appropriate a progress update since the previous meeting.

GP's provide leadership to most clusters and these leads gave positive views about the Health Board's oversight, although there are concerns about the time available to lead the clusters

- 104 **Exhibit 12** sets out the professional backgrounds of the cluster leads. Out of the seven clusters operating in Hywel Dda, six are led by a GP and the remaining cluster is led by a cluster manager.

Exhibit 12: professional background of the cluster leads

	Number of clusters leads: GPs	Number of clusters leads: other professionals	Total number of clusters
Abertawe Bro Morgannwg	11	0	11
Aneurin Bevan	9	3	12
Betsi Cadwaladr	12	2	14
Cwm Taf	5	6	8
Cardiff and Vale	9	0	9
Hywel Dda	6	1	7
Powys	2	1	3
Wales	54	13	64

Note: While the total number of clusters is 64, the total number of cluster leads is 67 because Cwm Taf has both GP and other professional leads for its clusters.

Source: Wales Audit Office, Health Board self-assessment returns.

- 105 The cluster leads in the Health Board are responsible for planning, oversight and management of the cluster. Cluster leads are recruited following open competition. The Health Board seeks expressions of interest and candidates are invited for interview. For the latest appointment, candidates were interviewed by the Director of Primary, Community and Long-Term Care together with the Assistant Director.
- 106 Public Health Wales, through the Primary and Community Care Development and Innovation Hub, has developed a Confident Leaders Programme, which has been attended by 40 of the cluster leads. The cluster leads continue to share and learn from each other through a community of practice. Only 3 of the respondents to our cluster survey in the Health Board have attended the Confident Leaders course.
- 107 In the Health Board, all respondents to cluster lead survey agreed that the Health Board provided them with effective support to undertake their cluster lead role. However, only one agreed that they have enough time in their day to focus on Cluster development. Cluster leads are paid one day per week for carrying out their role at the Health Board.
- 108 Cluster leads told us that the support provided to them by the Health Board has been effective as all respondents to our survey agree that they get effective support to undertake their role.
- 109 The Health Board monitors progress of the clusters through monthly Locality Network meetings, which allows for regular contact between the clusters and the Health Board. There are also quarterly cluster reports on finance and performance and any issues are reported to and discussed at the PCSC.
- 110 A Primary Care Annual Report is produced and reported to the main Board. In addition, a Primary Care Quality and Performance Assurance Report is produced bi-monthly and reported to the Primary Care Sub-Committee Three Counties Primary and Community Care Quality and Safety Committee and Improving Patient Experience Committee. A Primary Care Finance Report is produced monthly and discussed at the Primary Care Sub Committee.
- 111 There are, therefore, a range of fora which receive reports on Primary Care and there is a specific sub-committee of the Board which discusses Primary Care issues - the Primary Care Sub-Committee.

Performance: Performance against national targets remains below the rest of Wales in many areas and some difficult challenges remain

Many aspects of the Health Board's primary care performance against national targets are worse than the Welsh average

- 112 The Health Board's latest reported performance against national targets shows that it has made slight improvements in some areas but is still lagging behind the rest of Wales. **Exhibit 13** shows how the Health Board performed against key Welsh Government indicators as reported in the Board's Integrated Performance Assurance Report for May 2018.
- 113 In the report's assessment section there is narrative around which indicators are 'going well', 'potential challenges for the future' and those 'areas where improvements are needed'. In all three areas, no mention is made of the performance against the primary care indicators despite the Health Board being bottom of the ratings in two indicators and in the bottom half of performers in all others. This may be due to primary care performance issues being reported to the Primary Care Sub Committee, but a clear mechanism is required to provide assurance to the Board on primary care performance issues so that these are discussed and actioned.

Exhibit 13: reported performance against national indicators

Indicator	Target	All Wales	Hywel Dda	Rating	Better/worse from last report
Percentage of GP practices open during daily core hours or within 1 hour of the daily core hours	Annual Improvement	87%	73%	7 th out of 7	72.5% (B)
Percentage of GP practice offering daily appointments between 17:00 and 18:30 hours	Annual Improvement	84%	80%	5 th out of 7	76.5% (B)
Performance against selected Out of Hours service indicators (20 mins) – excluding Carmarthen	98%	62.8%	56.8%	5 th out of 6	n/a
Performance against selected Out of Hours service indicators	98%	67.3%	66.7%	4 th out of 6	n/a

(60 mins) – excluding Carmarthen

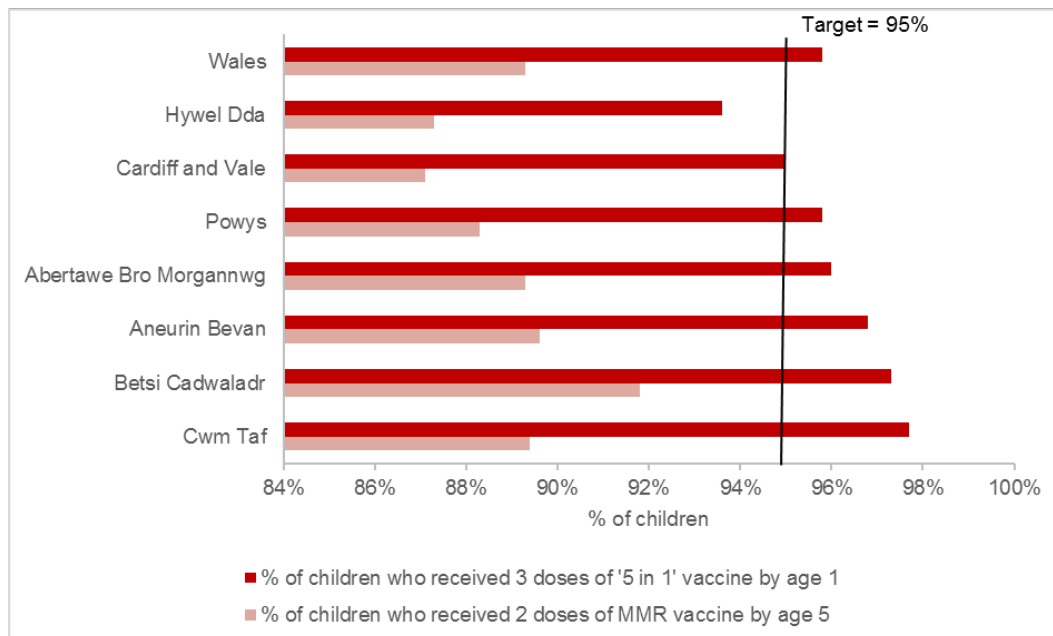
Percentage of the health board population accessing NHS primary dental care	Annual Improvement	54.9%	46%	7 th out of 7	n/a
Percentage of adults (age 16+) who reported that they were very satisfied or fairly satisfied about the care that they received at their GP/family doctor	Annual Improvement	89.7%	89.5%	4 th out of 7	No trend

Note: The Out of Hours Indicators exclude Carmarthen due to the roll out of the '111' service

Source: HB Integrated Performance Assurance Report- Month 1 May 2018

114 Exhibit 14 shows that child immunisation rates in the Health Board are amongst the lowest in Wales and the targets for the two KPIs were not met.

Exhibit 14: childhood immunisation rates for the quarter January to March 2018



Note: '5 in 1' vaccine protects against diphtheria, tetanus, pertussis (whooping cough), polio and hib infection. MMR protects against measles, mumps and rubella infections.

These results are for children living in the Health Board area in March 2018 and who reached their first and fifth birthdays during the quarter 1 January to 31 March 2018.

Source: Public Health Wales

115 **Exhibit 15** shows that the Health Board is meeting only one of the five primary care targets reported by Public Health Wales. Of the five targets, only the Cervical Screening Uptake target is being met. Apart from Breast Screening there has been a deterioration in performance in the other four areas when compared to the previous year 2015-16.

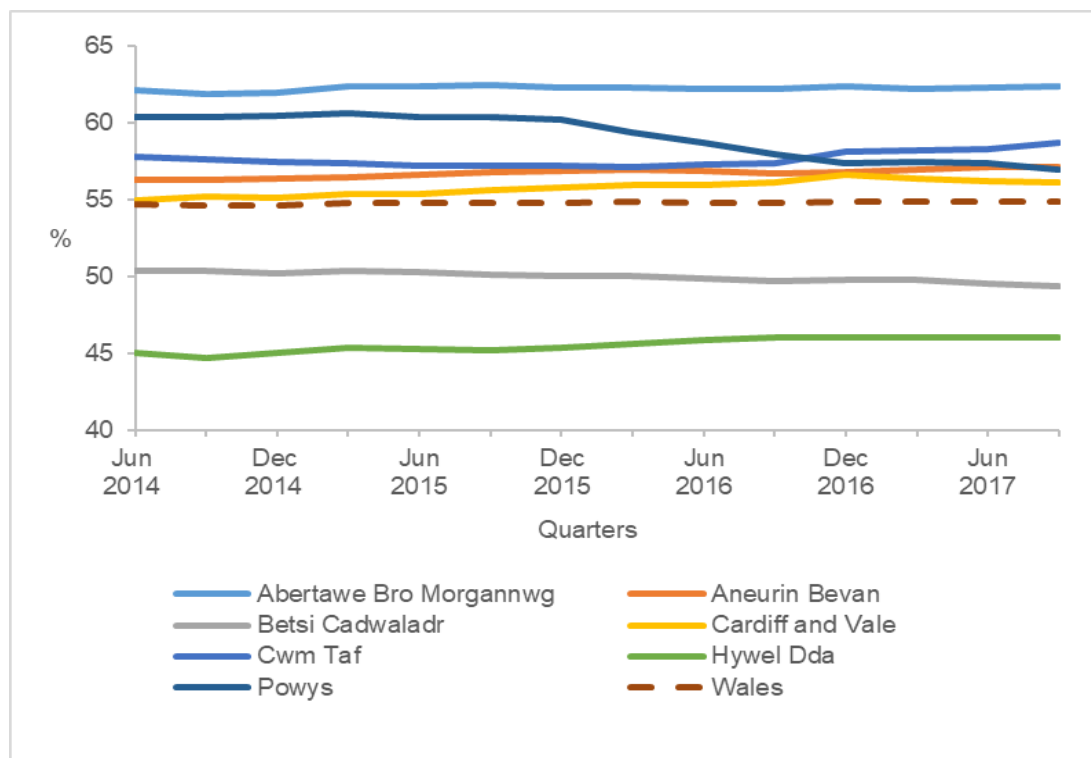
Exhibit 15: Public Health Wales primary care targets

Indicator	Target	All Wales	Hywel Dda	Report Period	Target met
Bowel Screening Uptake	60%	53.4%	54%	2016/17	No
Breast Screening Uptake	80%	73.1%	74.6%	1/11/17	No
Cervical Screening Uptake	80%	77%	80%	31/3/17	Yes
Flu uptake over 65	75%	66.7%	63.4%	2016/17	No
Flu Uptake Under 65 at risk	75%	46.9%	42.3%	2016/17	No

Source: Public Health Wales 2016/17

116 **Exhibit 16** shows the percentage of residents within the Hywel Dda area who were treated at an NHS dental practice in the previous 24 months. This shows that in the Health Board area, 46% of residents were treated. This compares with a Wales average of 54.9%. Hywel Dda was the worst performing health board in Wales.

Exhibit 16: percentage of residents treated at an NHS dental practice in the previous 24 months, as at September 2017



Source: NHS Business Services Authority: Dental Services

117 The Health Board’s Annual Report for 2017 describes several areas of improvement to primary care services that occurred during the year. These include more positive and open engagement with patients and communities; building skills and capacity in primary care; more integrated primary and community services through locality working; as well as improvements in GMS, oral health, community pharmacy and optometric services.

A number of challenges remain including recruitment and retention issues, difficulties shifting resources, financial pressures and increasing demand

118 Our review has highlighted barriers that need to be removed to ensure further progress is made in transforming primary care. We sought the views of staff through interviews, self-assessment and our cluster leads survey. Our interviews with staff indicated the following challenges need to be overcome to ensure further success in transforming services:

- Clear and transparent processes to allow the transfer of funding from secondary to primary care to support transfer of services.
- Current sustainability issues in Primary Care.
- Recruitment and retention of Primary Care staff.
- Ageing workforce, particularly amongst GPs and nurses.
- A change in the perception that the strategy is not about dumping work onto Primary Care.
- Improved IT, especially for operational and performance management and for manpower planning.
- Lack of engagement of all healthcare professionals in Cluster planning meetings.

119 We asked the Health Board what the barriers were when trying to transform primary care. **Exhibit 17** shows that budgetary constraints in ophthalmic services and recruitment of dentists are the main barriers.

Exhibit 17: Health Board’s view on barriers to transforming primary care

Barriers	What needs to be done to remove these barriers?
Moving budgets from Acute Care to Primary Care to ensure funding follows patient.	Have one budget in the organisation for Ophthalmology, Eye Health Examination Wales) EHEW and Low Vision Aids (LVS) in order to have a good understanding of the cost impact of further modernisation and the cost associated with individual care pathways.
Recruitment and retention of dentists.	Use contract reform to develop a more skilled mix approach to the delivery of Dental Care.

Source: Health Board self-assessment

120 We sought views from cluster leads on the successes that have been achieved and the main challenges facing primary care in the area. Several successes were highlighted as shown below:

- Cluster working has increased cooperation between practices.
- Closer working with social services and increased understanding of their limitations.
- Multidisciplinary team meetings.
- Cluster pharmacists’ impact on GP workload and promotion of prudent health care.
- Piloting of new schemes to allow Primary Care to help secondary care and help struggling practices.
- Shared social prescribing team.

- Clusters becoming a recognised forum for social services, secondary care, the third sector and the local community.

121 Cluster leads also raised a number of challenges as indicated below:

- Sustainability and recruitment/retention of Primary Care staff.
- Rurality. Poor public transport and road infrastructure. Travel time for both patients and Clinicians.
- Budget deficit.
- Staffing levels due to GP and nurse retirement and lack of succession planning.
- Workload. Increasingly complex patients and work coming in from secondary care, which is under resourced.
- Increasing expectations of patients demanding 24-hour care, the worried well. Unrealistic expectations by patients living a 24/7 culture.
- Lack of investment in improving community services with direct access from primary care.

Appendix 1

Methods

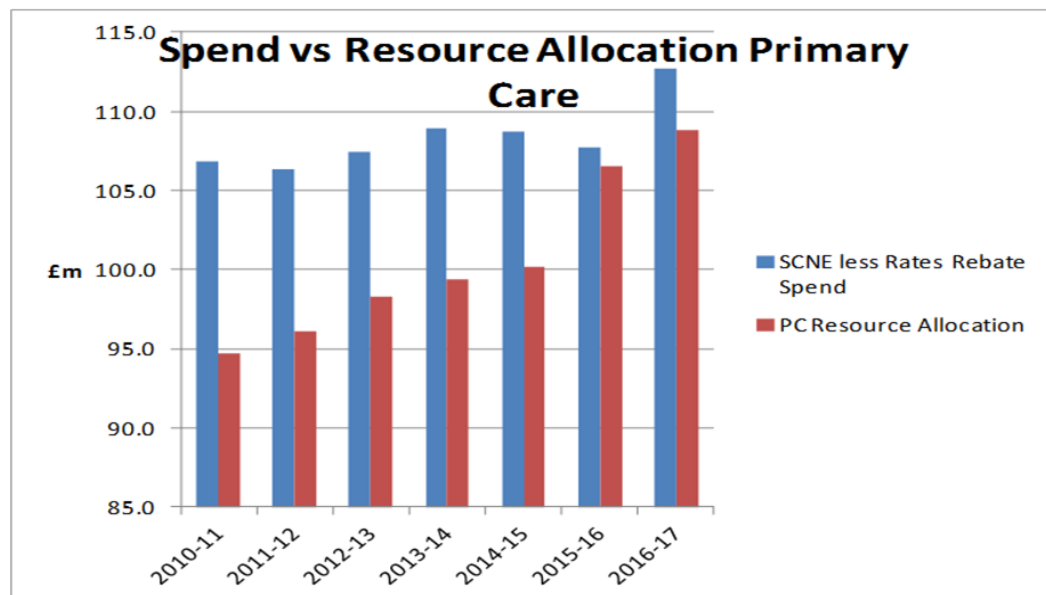
Method	Detail
Health Board self-assessment	The self-assessment was the main source of corporate-level data that we requested from the Health Board in February 2018. This tool also incorporated a document request.
Survey of cluster leads	We sent an online survey to all cluster leads in Wales in April 2018. The overall response rate was 63%. In the Health Board it was 71.4%.
Interviews	We interviewed several staff including the following with responsibility for primary care: <ul style="list-style-type: none">• Vice Chair• Executive Director responsible for primary care• Assistant Director- Primary Care• Associate Medical Director (Workforce & Primary Care)• Associate Medical director (Dental)• Finance lead• Workforce lead• Operational Managers• Community Health Council representative
Review of the Health Board's Integrated Medium-Term Plan	We reviewed the Health Board's medium-term plan to assess the extent to which primary care is considered.
Use of existing data	We used existing sources of data wherever possible such as Welsh Government and Public Health Wales statistics.

Appendix 2

Alternative primary care spending data

- 122 The Health Board report that the information used to compile Exhibits 5 and 7 has been derived from Note 3.1 of the Annual Accounts and do not provide an accurate picture of expenditure in Primary Care. They state two reasons for this.
- 123 The figure for the difference between drugs dispensed and prescribed has been deducted from expenditure in Note 3.1. Since this adjustment relates entirely to medicines it would give better representation of spend if this is not counted as Primary care spend (see red line on Exhibit 18 below). Some costs and staff costs which relate to Primary Care have been included elsewhere - Notes 3.2 and 3.3.
- 124 There was also a non-recurring cash benefit from Primary Care rate rebates in 2016-17 which further distorts the overall picture. Recent expenditure variances include:
- 2015-16 – Net reduction in spend £1.0 million**
- Increase in expenditure due to investment of primary care funds -£1m
 - Reduction in dental expenditure of £1.5 million due to contractor underperformance in year.
 - Reduction of £0.7 million in Community Pharmacy spend due to the National UK pricing mechanism.
- 2016-17 – Net increase in spend £1.3 million**
- Increase in ophthalmic spend of £1.0 million due to accounting methodology.
 - Additional investment of £0.2 million new primary care funds
 - Net credit of £3.7 million from rates rebate, reducing in year spends,
- 125 During the period, expenditure on primary care has always exceeded the resource allocations specifically allocated to primary care contracts. See Exhibit 18 below.

Exhibit 18: spend versus resource allocation for Primary Care (HB version)



Source: LHB Self-Assessment

- 126 The Health Board note, however, that the exhibit would be different if the non-recurrent effects in 2016-17 are excluded. In addition, it can be shown that Primary Care spend as a % of total spend has fallen by 2.0% in the period during which time Primary Care resource allocation as a % of total resource allocation income has decreased by 1.5%.
- 127 If this is adjusted for non-recurring gains, then the Primary Care spend as a % of total spend has fallen by 1.5% in the period during which time Primary Care resource allocation as a % of total resource allocation income has decreased by 1.5%.

Appendix 3

Health Board's response to the recommendations

When the relevant committee has considered this report, we will insert a shortened version of the Health Board's response in the report before we publish it on the Wales Audit Office website.

Exhibit 19: management response

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1	Develop the necessary consultation and communications plans to ensure meaningful public and stakeholder engagement in any further development/refinement of its primary care plans.	To encourage public support for the primary care plans.	Yes	Yes	Public engagement plans already in place for GMS contract changes and will be used and adapted to enable further development/refinement of public and stakeholder engagement	Completed	Assistant Director Primary Care
R2	Develop a clear financial cost analysis to support its primary care plans to ensure its plans are affordable and to set out how it will fund any planned changes.	To understand funding requirements to support primary care plans.	Yes	Yes	Primary care reports are produced on a monthly basis that monitor the achievement of primary care budgets and report on any over or underspends. Longer term plans for primary and community care will be developed through the IMTP and TCP process.	January 2019	Assistant Director Primary Care

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R3a	Calculate a baseline position for its current investment and resource use in primary and community care.	To establish a baseline from which to measure the resource shift towards primary care.	Yes	Yes	The Health Board needs to set the baseline for expenditure in primary and community care based on the information used to produce its audited annual accounts. A plan for implementation of the baseline needs to be compiled and implemented to reflect services at 31st March 2019. Changes will then be measured relative to this baseline annually.	April 2019 and ongoing	Senior Business Partner
R3b	Review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care.	To understand progress made in moving resources from secondary to primary care.	Yes	Yes	The shift of resources into primary and community care can be monitored on an annual basis using the information that forms the basis of the Health Board's audited accounts. The shift of resources needs to be measured in accordance with the national paper dealing with the transfer of services and resources to primary care.	April 2019 and ongoing	Senior Business Partner

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R4a	Ensure the contents of its Board and committee performance reports adequately cover primary care.	To increase the Board's understanding of primary care performance	Yes	Yes	Regular reports are already being considered by the Board and its associated committees.	Completed and in place.	Assistant Director Primary Care
R4b	Increase the frequency with which Board and committees receive performance reports regarding primary care	To increase the Board's understanding of primary care performance	Yes	Yes	Regular reports are already being considered by the Board and its associated committees.	Completed and in place.	Assistant Director Primary Care
R4c	Ensure that reports to Board and committees provide sufficient commentary on progress in delivering Health Board plans for primary care, and the extent to which those plans are resulting in improved experiences and outcomes for patients	To raise Board awareness of the impact of primary care transformation on patients.	Yes	Yes	Regular reports are already being considered by the Board and its associated committees.	Completed and in place.	Assistant Director Primary Care

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R5a	Develop and implement an action plan to obtain regular, comprehensive, standardised information on the number and skills of staff, from all professions working in all primary care settings.	To have a clear understanding of the whole primary care workforce, which will be the basis for current and future workforce planning.	Yes	Yes	Annual census data collated for WG and used to inform discussions on future workforce. Included within the IMTP.	Completed. Process in place for annual review of data which is requested locally and nationally.	Assistant Director Primary Care Head of Workforce
R5b	Revisit its primary care workforce plans to ensure they take account of the issues arising from the Transforming Clinical Services programme.	To ensure that the workforce plans are aligned.	Yes	Yes	Work is ongoing to understand the current staffing within primary care across the contractor professions to ensure that the Primary Care Model for Wales is implemented.	October 2019	Assistant Director Primary Care Head of Workforce
R6a	Review the membership of clusters and attendance at cluster meetings to assess whether there is a need to increase representation from local authorities, third sector, lay representatives and other stakeholder groups.	To ensure clusters have the right representation.	Yes	Yes	A review of cluster membership etc to be undertaken in line with the Primary Care Hub report on Cluster Governance	April 2019	Assistant Director of Primary Care

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R6b	Encourage all cluster leads attend the Confident Primary Care Leaders course.	To strengthen cluster leadership.	No	No	The Confident Leaders programme is due to change focus to Aspiring Practice Managers therefore this will not be possible. The Health Board will however look to support the development of its cluster leads locally.	October 2019 and review annually through review of cluster leads objectives	Director of Primary Care
R7a	Work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models.	To establish a robust evidence base of benefits to help inform decision making	Yes	Yes	This will be undertaken in line with the Primary Care Hub report on Cluster Governance	April 2019	Assistant Director of Primary Care
R7b	Subject to positive evaluation, begin to fund new models from mainstream funding rather than the Primary Care Development Fund.	To help ensure a long term future for new models of care	Yes	Yes	To be considered in line with the Primary Care Model for Wales, the IMTP and the shift of funding within the system to support service change and remodelling.	October 2019 plus ongoing review.	Assistant Director of Primary Care
R7c	Work with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce demand for GP appointments.	To educate the public about alternative first points of contact available.	Yes	Yes	Public engagement plan regarding access to all primary care services to be developed and implemented.	October 2019	Assistant Director of Primary Care

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